§ 58-50-82. Expedited external review.

(a) Except as provided in subsection (g) of this section, a covered person may file a request for an expedited external review with the Commissioner at the time the covered person receives:

(1) A noncertification decision under G.S. 58-50-61(f) if:

a. The covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited appeal under G.S. 58-50-61(l).

(2) An appeal decision under G.S. 58-50-61(k) or (l) upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited second-level review of a noncertification as set forth in G.S. 58-50-61(i); or

(3) A second-level grievance review decision under G.S. 58-60-62(h) or (i) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) Within two days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external review and, if it is eligible, determine whether it is eligible for expedited review.

a. For a request made pursuant to subdivision (a)(1) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review

of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered person must exhaust, at a minimum, the insurer's internal appeal process under G.S. 58-50-61(l) before making another request for an external review with the Commissioner.

b. For a request made pursuant to subdivision (a)(2) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered person must exhaust the insurer's internal grievance process under G.S. 58-50-62 before making another request for an external review with the Commissioner.

c. For a request made pursuant to sub-subdivision (a)(3)a. of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis

because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

d. For a request made pursuant to sub-subdivision (a)(3)b. of this section, that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.

(c) As soon as possible, but within the same day after receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method. A copy of the same information shall be sent by the same means or other expeditious means to the covered person or the covered person's representative who made the request for expedited external review.

(d) In addition to the documents and information provided or transmitted under subsection (c) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.
(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.
(6) Medical necessity, as defined in G.S. 58-3-200(b).
(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than three days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision

and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(k).

Upon receipt of the notice of a decision under subsection (e) of this section that reverses the noncertification, noncertification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the noncertification, noncertification appeal decision, or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification appeal decision, or second-level grievance review decision.

(g) An expedited external review shall not be provided for retrospective noncertifications. (2001-446, s. 4.5; 2005-223, ss. 10(b), 11, 12; 2007-298, ss. 3.1, 3.2; 2009-382, ss. 28-30; 2013-199, s. 10; 2015-281, s. 9.)